Predoctoral Psychology Residency Program

2007-2008

Veterans Health Administration
Medical Center
Dayton, Ohio

Inquiries and application materials should be addressed to:

Director of Training
Psychology Residency Program (116)
VHA Medical Center
4100 West Third Street
Dayton, Ohio 45428

Phone: 937.268.6511 Ext 2657
FAX: 937.267.3924
Email: 552internship@med.va.gov

National Matching Service Program Code

151211	General Psychology Internship
151212	Pre Post Doc Neuropsychology

Accredited by the American Psychological Association
Committee on Accreditation
750 First Street, NE
Washington, DC 20002-4242
202.336.5500

Member of the Association of Psychology and Postdoctoral Internship Centers
10 “G” Street, NE Suite 440
Washington, DC 20002
202.589.0600

TABLE OF CONTENTS

OVERVIEW

The Veterans Health Administration (VHA) is part of the Department of Veterans Affairs which is a cabinet level organization. The VHA Medical Center, Dayton, Ohio offers a full time, one year, funded predoctoral residency to doctoral students enrolled in clinical or counseling psychology programs that are accredited by the American Psychological Association (APA). Our psychology residency program is accredited by the APA. The next regularly scheduled site visit will be during 2006.

The origin of the Dayton VHA Medical Center dates back to March 3, 1865, when President Abraham Lincoln signed into law an act of congress establishing the National Home for Disabled Volunteer Soldiers to care for disabled veterans of the Union Army. Dayton, Ohio was one of three original sites selected. Originally, the grounds consisted of 355 acres west of the city of Dayton. Lakes, surrounded by scenic trails, provided a relaxing atmosphere for relaxation and rehabilitation. A large farm provided much of the produce used by the residents. By the turn of the 19th to the 20th century, Dayton was the largest facility in the National Soldier's Home System. During 1930, when the Veterans Administration was formed, the National Solder's Home System was discontinued and incorporated into the new organization. During 1989, the Veterans Administration was made a cabinet level organization and the title was changed to the Department of Veterans Affairs.

The medical center is located at the west edge of Dayton, Ohio. Much of the pastoral setting was preserved while establishing a modern, state of the art comprehensive medical facility. The current complex consists of approximately 60 buildings on about 240 acres. The medical center provides a broad spectrum of programs in primary, secondary, and most levels of tertiary care. The medical center serves 29 counties in central and western Ohio along with one county in Indiana with a total patient population of about 380,000. There are approximately 6500 inpatient stays and 200,000 outpatient visits each year. The medical center is a teaching facility that has numerous affiliation agreements with colleges, medical centers, medical schools, universities, and training programs throughout the area along with sharing agreements with other medical centers in the area and the Department of Defense. The medical center has excellent research facilities along with administrative and clinical support of such activities. The Dayton Department of Veterans Affairs Medical Center is a well established multicultural setting that employs about 1600 full-time employees who reflect considerable diversity.

RESIDENCY TRAINING PROGRAM

Philosophy

We believe the residency year is crucial in the transition of the individual from student to professional. We encourage the development of professional knowledge, skills, and beliefs/attitudes that form the basis for a solid professional identity along with the

competent practice of psychology. We encourage individual professional responsibility while recognizing the importance of communicating and sharing responsibility with other professionals. Residents are encouraged to be innovative and creative with their professional development while using well established principles, techniques, and procedures as a basis for professional activities. In the perennial balance of medical center and training needs, we recognize that a high quality training program must be designed for the needs of the residents.

Title

We use the title of Psychology Resident in order to be consistent with the titles used in this medical center. Also, two other accredited programs in the immediate area use the same title. The title is equivalent to the more frequently used title of Psychology Intern.

Model

The Psychology Residency Program is based on the Vail (Practitioner-Scholar) Model. Within the context of the practice of psychology, the mutually interdependent roles of science and practice are recognized and applied within a public service setting. The Practitioner-Scholar Model is consistent with the tripartite mission of the VHA: patient care, education/training, and research.

Mission

We take pride in our profession and in the training of residents to become psychologists. We recognize the special responsibilities associated with the training of residents. The mission of the Psychology Residency Program is to establish and maintain an environment that maximizes the potential for professional development for each psychology resident.

Approach to Training

There are various forms of supervision. Within the residency program, we define supervision by using the term “Supervision for the Purpose of Training.”

- Inherent in supervision for the purpose of training is a complex social relationship that is operated on a number of levels simultaneously. We recognize, and are sensitive to, the multiple levels.
- Supervision for the purpose of training has four components.
  - Formal knowledge
  - Skills/experience
  - Attitudes/beliefs
  - Insure safety of patients
- Supervision for the purpose of training has a developmental quality.

We utilize a programmatic approach to training. Within a programmatic approach, each resident enters an ongoing patient care system and performs the duties of a psychologist. Within the context of programmatic approach, the apprenticeship approach is utilized to varying degrees. Variation is due to the specific needs of each resident and the tasks being learned.

We have adopted situational leadership theory as our conceptual basis. The role of a training supervisor evolves as a resident develops competence in a given task: direct, coach, consult, independence. The theory is elegant in its simplicity and incorporates well the developmental nature of a psychology residency.

Within the various guidelines, rules, regulations, laws, standards of care, and models that govern our professional behavior, training is individualized in order to meet the professional needs of each resident. There is a proactive dialogue among all relevant parties that begins before, and continues throughout, the residency year.

Our general approach is to behave in a manner consistent with American Psychological Association guidelines and Department of Veterans Affairs Policies regarding the disclosure of personal information and to routinely maintain good boundaries in that regard. Legitimate training supervision activities include, but are not limited to, the exploration of professional and personal values, the exploration of personal experiences along with their impact on the practice of psychology, the development of understandings regarding emotional reactions to events that occur during the course of professional activities, and the exploration of consistencies/inconsistencies between one's personal behavior patterns and behavior patterns that are consistent/inconsistent with good health and quality of life.

The general design of the Psychology Residency Program is quality assurance. We developed a specific, competence based approach. The competencies notion is applied to all aspects of the training program. Within the context of a quality assurance structure, both positive and negative feedback have equal value. Each serves to inform how well an element or process is functioning.

The Lead Psychologist and the CoDirectors of Training are administratively responsible for the Psychology Residency Program while the Psychology Training Committee is the general body. Regular meetings are held and the minutes are distributed to all staff and residents. Residents are members of the training committee. A training supervisor who is actively supervising is required to attend all meetings. A training supervisor who is not actively supervising a resident is not necessarily required to be at all meetings, but attendance is recommended. Although the members of the training committee work toward consensus when making decisions, a simple majority vote is all that is required.

Goals

We designed the residency program to provide a broad predoctoral training experience that forms a sound basis for a professional career. The focus is on the acquisition

and/or development of formal knowledge, professional skills, and attitudes/beliefs that make for a solid professional identity. The expectation is that, by the end of the training year, a resident will be able to function competently (i.e., entry level or better) in five core areas: Ethical/Professional Issues, Assessment, Intervention, Diversity/Multicultural, and Science and Practice. We emphasize general skills. Within the context of sound professional growth, however, we support actively the development of specialist skills.

Objectives/Competencies

Our overall goal is for each resident to be fully prepared for entry level practice. Entry level practice is defined as being fully prepared to begin the required period of supervision prior to licensure. It is the equivalent to a GS-11 psychologist in the Department of Veterans Affairs.

The core areas of Ethical/Professional Issues and Diversity/Multicultural are essentially the same for all rotations. Each rotation has some unique competencies in the core areas of Assessment, Intervention, and Science and Practice. The competencies are documented in the form of competency grids. What follows are generic statements that provide a reasonable guideline for the purpose of communication through a brochure.

Ethical/Professional Issues

Ethical/Professional Issues is a collective term that includes the many behaviors inherent in the many roles of a professional psychologist. Many do not fit easily into well defined categories.

- Observance of the American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct, and Department of Veterans Affairs rules, regulations, and laws as well as other documents that govern our professional behavior.
- Ability to engage effectively in the various processes involved in a residency.
- Dependable professional demeanor consistent with the practice of psychology.
- The ability to monitor one's professional behavior along with the provision of unimpaired psychological services.
- Ability to understand the nature of his or her behavior within the context of each rotation.
- Knowledge of one's personal and professional strengths and limitations along with the recognition of the need to seek assistance or refer.
- Ability to recognize and deal with personal and professional issues in a constructive manner: e.g., use of supervision.
- Awareness of the nature of the impact of one's professional behavior.
- Appreciation for the power inherent in one's position relative to others.
- Management of time.

Assessment

Assessments are a unique role for psychologists. We perform a variety of assessments and each resident is required to demonstrate competence with the types of assessments involved in a given rotation. The expectation is that by the end of the residency year, each resident will have completed a wide variety and large number of assessments. At the beginning of the residency year, it is important to plan experiences so that there is variety in the nature and content of the assessments.

- All assessments involve a referral question (i.e., purpose). Each resident is required to demonstrate proficiency in understanding and explaining the nature of each referral question. If the nature of the referral question is not clear, the resident must clarify it with the referral source.
- Procedures
  - Selection of Procedures: For any given referral question, a variety of assessment procedures are possible. It is important to select the types and numbers of procedures that provide meaningful information. Each resident is required to become familiar with the concept of incremental validity and be able to apply it to actual situations.
  - Record Review: In most cases, medical records will be available. Each resident is required to be familiar with medical records along with usual and customary medical terminology.
  - Interview: Each resident is required to demonstrate competence in interviewing techniques: Mental status, open ended questions, content related to the referral question, etc.
  - Test Administration and Scoring: Actual test procedures utilized will depend upon the nature of the referral question and the rotation. Each resident is required to demonstrate proficiency in administration and scoring of tests.
- Interpretation of the Data
  - Each resident is required to demonstrate competence in interpreting data in a reasonable manner relative to the referral question.
- Written Report
  - All assessments require written documentation designed to meet the needs of the person - sometimes multiple persons. Each resident is required to demonstrate proficiency in writing clear, cogent reports that involve the integration of data in a coherent manner.
- Feedback
  - The provision of feedback in a manner that a patient can understand is a necessary professional skill. Also, in many cases, feedback to the referral sources is indicated as well. Each resident is required to demonstrate proficiency.

Intervention

Intervention occurs within the context of a special socially sanctioned relationship designed to maximize change in one party. Interventions are literature based and utilize

well established psychological knowledge and principles. Psychologists perform a variety of interventions. Each resident is required to demonstrate competence with the types of interventions required for a given rotation. At the beginning of the residency year, it is important to plan well to insure some variety in the types of therapy and patients treated.

- Conceptualization/Theoretical Orientation: A wide variety of conceptualizations and/or theoretical orientations are considered acceptable in the practice of psychology. Each resident is required to articulate a theory and/or conceptualization for each intervention.
- Modality: A fairly wide variety of treatment modalities are recognized in the practice of psychology. Each resident is required to demonstrate competence in the selection of a treatment modality that is appropriate to a given case. Emphasis is placed on intervention strategies that have a degree of verified effectiveness.
- Treatment Planning: The development of specific, attainable goals is important in interventions. Each resident is expected to be able to identify functional, measurable goals for each intervention.
- Process: Interventions are complex interpersonal processes. Each resident is expected to demonstrate competence with those processes relative to each rotation. Some examples are:
  - Personal and professional knowledge of self along with an awareness of one's impact on the therapeutic process.
  - The establishment and maintenance of feedback mechanisms utilized during the therapeutic process.
  - Identifying and processing one's own emotions as part of the therapeutic process.
  - Awareness of cause and effect relationships between one's behavior and change in a patient.
  - Ability to predict the consequences of one's specific intervention, comment, or behavior.
  - Timing of a specific intervention, comment, or behavior.
  - Awareness of boundaries with a given patient.
  - The presentation of clear and consistent messages to a given patient along with the avoidance of mixed or inconsistent messages.
  - Recognition when therapy has been completed or has become counterproductive.
  - Awareness of and ability to articulate when and how a relationship is therapeutic or not therapeutic in nature.
- Termination. There are various, acceptable reasons for termination of a case. Each resident is required to demonstrate the ability to terminate cases appropriately.

Diversity/Multicultural

Each resident is required to demonstrate competence in providing psychological services to individuals from diverse backgrounds: different ethnic histories, gender issues, sexual orientation issues, disabilities, unique experiences of veterans, etc.

Science and Practice

We are a rather fast paced patient care oriented setting. Consequently, our residency program has a practice focus. However, research influences practice and practice influences science. The use of relevant literature is an integral part of each rotation. As part of a given rotation, each resident is required to demonstrate and ability to use a quality literature base and apply it to professional practice through one or more of the following.

- Completion of a literature search on a specific subject and applying the knowledge during the rotation.
- Reading current literature on a subject related to the rotation and applying the knowledge.
- Participation in ongoing research.

Completion

Completion of the residency program is conditional upon a resident meeting the stated objectives along with professional behavior that meets or exceeds competencies. No partial credit is granted regarding the residency. Successful completion of the residency is an all-or-none decision.

Evaluation

Evaluations are an integral component of the residency training process and occur throughout the residency year. At the beginning of each rotation there is a general assessment of a resident's professional skills. There is a more formal assessment of competencies about half way through a rotation and at the end of each rotation. At the end of each rotation, the resident completes a competency form on the supervisor. Also, at the end of the residency year each resident completes formal evaluations of the program.

ROTATION FORMAT AND ASSIGNMENT

The basic rotation structure is three four month rotations with each resident spending one day per week in the Mental Health Clinic for the entire residency year. Any group of three rotations plus the one day per week in the Mental Health Clinic is consistent with our objectives/competencies. The one day per week in the Mental Health Clinic does

not preclude a four month rotation in Mental Health. In other words, one may do both. However, based upon feedback from prior residents, we have learned that the one day per week in the Mental Health Clinic is sufficient for training purposes. Residents who desire a full rotation in Mental Health are assigned to the Inpatient Mental Health/Emergency Room.

Consistent with the updated guidelines and principles of accreditation, there will be contact between the training committee and a resident's graduate program prior to the onset of the residency year. Also, there will be interactions between the residency program and the residents. The goal is to have rotation structure in place prior to the beginning of the residency year.

We recognize that after arrival and familiarization with the setting, a resident may wish to change a rotation and/or the sequence of rotations. Also, professional development plans can, and do, change. Our preference is for such changes to take place early during the residency year (the first couple months) in order to maximize predictability for all parties concerned.

Based upon feedback from prior residents, the Psychology Training Committee decided to adopt a 6-2-4 structure for individuals who have a well organized professional development plan that includes emphasis or specialization. The decision is made on a case by case basis and we anticipate meeting such requests.

ROTATIONS AND CONCEPTUALIZATION STATEMENTS OF TRAINING SUPERVISORS

Training supervisors are psychologist whose responsibilities include the provision of supervision for the purpose of training. The statements are similar to the conceptualization statements written by applicants with an orientation toward the setting in which the supervisor engages in the practice and training of professional psychology.

Health Psychology

Description

The rotation in health psychology emphasizes the provision of psychological services in the medical primary care clinics at the medical center. Such services include: assessment of patients referred for a variety of issues – most commonly depression, anxiety, substance abuse, nonadherence to indicated treatment regimens, adjustment to medical conditions/disabilities, psychological factors impacting presentation of medical symptoms, and stress management. Interventions offered to primary care patients typically include brief, time limited treatments as well as psychoeducational activities such as health education groups. Each resident will become involved with the

primary care team that consists of physicians, nurses, a psychologist, physician assistants, dieticians, a social worker, a pharmacist, and administrative associates.

Psychologists assigned to health psychology provide a range of other services. Such services include programs for chronic pain management, weight management, smoking cessation, and problems in sexual health. Consultation services are provided to specialty clinics and inpatient wards: cardiology, infectious disease, neurology, oncology, surgery, and rehabilitation. Also, health psychology is responsible for conducting evaluations of patients who are candidates for an organ transplant and bariatric surgery.

While many of the training activities and professional responsibilities are established as part of the routine program, the rotation is designed with an orientation toward flexibility to meet a resident's specific professional interests and needs. One of the explicit competencies in all rotations is the provision of consistent messages to patients. A resident can anticipate an exploration of his/her personal behavior patterns (e.g., use of nicotine products) relative to behavior patterns that maximize good health and quality of life. Supervisors: Dr. Frederick Peterson, and Dr. Ramon Verdaguer.

Conceptualization Statements

Frederick Peterson, Psy.D.

My conceptualization statement addresses two overlapping areas of my clinical activity within the field of health psychology, sex therapy and tobacco use treatment. When assisting people in need, I find it impossible to exclude the numerous influences on the formation of my professional perspective on human nature and the practice of psychology. Certainly the teachings of James, Maslow, Rogers, Adler, Albee, Ellis, and Perls come to mind.

The three most influential people in my professional life happen to be my former supervisors. I've been fortunate to have studied with three people I consider leaders of their field, if not pioneers. They are Dr. Ron Fox, past president of APA; Dr. William Masters, pioneer sex researcher and co-founder of the Masters and Johnson Institute, and Dr. Judy Seifer, past president of the American Association of Sex Educators, Counselors and Therapists (ASSECT).

As founding dean of the School of Professional Psychology at Wright State University, Dr. Fox taught me the importance of getting psychology "out of the box" of just having people coming to me in my office and doing traditional talk therapies. I see my calling in psychology, especially health psychology, as integrating psychologically sound principles and practices into all slices of normative life, such as child birthing, the transition into parenthood and becoming a family. Psychology should not be restricted and conceptually segregated from everyday life, just "on call" for those experiencing crisis in their life. When I am doing talk therapies, I find myself being as much of a

health educator as I am a psychologist. Also, I tend to use what works in therapy with a particular client (eclectic pragmatism), whether that involves movement, trying to solve a riddle or singing.

My theoretical emphasis on the teachings of George Albee and Ron Fox lead me to be active in teaching and prevention work. Much of that is done outside the Department of Veteran Affairs, particularly at Wright State University, University of Dayton and other hospitals. At the VA, my interest in prevention led me to start the smoking cessation education classes seventeen years ago. Today, smoking is widely accepted as the number one preventable cause of death in the country and smoking cessation is considered the "gold standard" of cost/benefit ratios within all of medicine and healthcare. Ironically, applied psychology as a whole has little involvement with smoking cessation relative to other healthcare professions.

For two years, I chaired a group a statewide group of smoking cessation specialists which developed a "best practice model" within the Department of Veteran Affairs. The interventions within the best practice model are based upon a strong theoretical foundation of three interlocking models. The first is the Nicotine Addiction Model, developed by many but championed by Alan Lesher (the former Director of National Institutes of Health), which basically perceives nicotine dependence as a brain disease within a social context. Secondly, Prochaska and DiClemente's Transtheorectical Model of Change is emphasized and applied to smoking cessation, as it has been applied to about every other form of human behavior. Finally, a Three-Factor Model developed by Gary DeNelsky at the Cleveland Clinic was incorporated into the best practice model. This Three-Factor Model addresses nicotine addiction, behavioral associations or "linkages" to smoking and a special set of "psychological meanings" tobacco use has for the smoker.

My work with Drs. Seifer and Masters occurred during my increasing observations about how sexual concerns so often occurred in therapy yet there where so few means of competently addressing these concerns within the teachings of traditional psychology. In my opinion, this state of affairs continues today as reflected by the divisional organization of APA, which has nearly sixty professional divisions but not one committed to sexual health.

The term "Sexual Health" is defined as the integration of the physical, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and enhance personality, communication and love (World Health Organization, 1992). The concept of sexual health developed from the writings of the sexosophers of the 19th century (such as Freud, Ellis, Van de Velde) and the sexologists of the 20th century (especially Kinsey, Masters and Johnson, Kaplan, Bancroft and Money). This collective body of writing provided the theoretical foundation to the development of an entirely new health profession - sexual health.

Sexual health is a multidisciplinary field that includes sex education and sex therapy. It conceptualizes sexual functioning as a natural state and disruptions to sexual

functioning as typically multicausal and needing intervention on multiple levels for optimal treatment outcome. The field of sexual health and sex therapy is regulated through a code of ethics developed by a professional body called the American Association of Sex Educators, Counselors and Therapists (AASECT).

Contingent upon this theoretical foundation, the Sexual Health Clinic at the VA Medical Center addresses the concerns of male and female veterans and their partners, which include, but are not limited to, sexual dysfunction, sexual trauma, sexual compulsiveness, gender dysphoria disorders and issues of sexual orientation.

Ramon Verdaguer, Ph.D., ABPP (Clinical Health Psychology)

It is now well understood that many chronic medical illnesses such as coronary artery disease, diabetes, and hypertension, whose causes include strong behavioral components, are readily preventable. As a result we are gradually experiencing a shift in focus from treatment of disease to illness prevention. This is especially so in the VA Healthcare system where much attention is given to primary care programs and primary care based interventions. Counseling about the health risks of smoking, and alcohol use as well as the benefits of exercise, seat belt use, and a healthy diet, is now commonly integrated into routine primary care visits.

One of the roles of a psychologist in the primary care setting is to facilitate change in people who have identified the implementation of healthy behaviors as an effective mean to prevent and/or manage chronic illness and are prepared to embark in such a change. The Transtheoretical Model (Prochaska & DiClemente), a process theory of change, is a useful construct in determining who may be ready to embark in that change and to which interventions they may be more receptive.

Although skill acquisition and enlargement is an objective, the underlying goal is to assist in the development of a self-regulatory mechanism that can maintain and drive those positive behaviors on a long-term basis in the face of occasional lapses, frustrations, and lack of concrete positive feedback and reinforcement. The concept of *integration*, as defined by Deci et al. (1994) in the Self-Determination Theory perspective, in which a behavior is “volitional” and “emanates from oneself” and results in self-determined behavior seems to capture the essence of this aim. A combination of psycho-educational strategies, client-centered and cognitive-behavioral therapeutic interventions are useful in enabling individuals to attain this level of integration.

Yet, we also know that availability of information and education about the consequences of high-risk behaviors and the availability of alternative health behaviors does not always translate into positive behavior change. In that light, another role of the psychologist is to promote behavior change with those people who may not be necessarily ready or prepared to undertake such a change. In this case, it is important to acknowledge that people may not be ready to change for a variety of reasons. Some of these reasons may be the result of intrapersonal issues such as perceived susceptibility, low self-efficacy, ability, and outcome expectations. Environmental issues

can also impact the decision to change and may include situational barriers or lack or resources and demographic or sociological variables. Clearly, the nature and severity of the illness can also impact on decision to change. The biopsychosocial model is, therefore, a useful umbrella framework through which we can conceptualize the individual and the factors influencing readiness to change. It lays out an outline for inquiry that can lead to an actionable roadmap for intervention.

In general, the orienting principle of my work is to assist people to act in ways that are consistent with their life values and goals. As such, I conceptualize my work as involving 2 phases. The first phase moves forward the process of value elucidation, goal determination, and choice clarification. Cognitive, emotive, and experiential strategies tend to be most effective in this phase. This process leads to the second phase, which involves facilitating decision making and actions that are consistent with attainment of the goals. Behavioral strategies tend to have a good response during this phase.

This process implicitly accepts that some people's values and goals are not necessarily congruent with the majority's values and that not everyone can, will, or should change. This may at times be incongruent with the institutional goals but its acceptance is crucial if one is to respect the individual and if one is to remain vitally committed to good patient care without losing oneself in the process.

Mental Health

Description

The program is structured such that, regardless of rotation setting, each resident spends one day per week in the Mental Health Clinic setting for the entire residency year. The arrangement is intended to provide residents with the opportunity to follow patients for the purpose of therapy on a more long term basis. Our experience has been that one day per week in this setting is sufficient for the purpose of learning.

When a resident selects a four month rotation in Mental Health the emphasis will be on provision of outpatient mental health interventions from an Integrative Cognitive Behavioral model, incorporating aspects of Dialectical Behavior Therapy, ACT (Acceptance and Commitment Therapy) and Motivational Enhancement Therapy. A major emphasis on this rotation is placed upon delivering treatment in a group format. There is also opportunity, however, for application of these models in an individual psychotherapy format. Supervisor: Dr. Rebecca Graham.

Conceptualization Statements

Arthur Aaronson, Psy.D.

I learned in graduate school that the goal of psychotherapy is to make the unconscious, conscious. I don¹t know too may therapists that do that these days, certainly not I. I

have come to the realization that the goal of psychotherapy is to reduce the level of discomfort that a client/patient is experiencing. Make a patient more comfortable often means that the therapist reduce symptoms, improve relationships, change lifestyles and/or help the patient accept the their unique circumstances.

If pressed to define the way I perform psychotherapy, I tell people that I am eclectic with a dynamic bias. In reality, therapy for me is like reading a Sherlock Holmes novel (or more topically, Johithan Kellerman or Steven White). Often we will just talk about what has been problematic for them during the time between the sessions. Sometimes, when we do a history, the patient might notice parallels in the behavior of other member of their family and their behavior.

I spend a lot of time with assessment and using tests like the Minnesota Multiphasic Personality Inventory--2 to help the patient/client see themselves like they are seen by others. This view is often the beginning of the trail to find out how the patient/client developed.

Rebecca Graham, Ph.D.

My clinical practice within the Mental Health Care takes place in two settings: the Acute Inpatient Mental Health Unit and the Outpatient Mental Health Clinic. I view human behavior as being multi-determined, with assessment and interventions needing to be multi-dimensional and functional, in nature.

The goal of acute inpatient mental health treatment is to return the patient to baseline behavior and functioning as rapidly as possible. Because of that, on our unit there is a heavy reliance upon biological treatments but psychological and environmental interventions are not neglected. As I psychologist, I use primarily interpersonal and cognitive-behavioral perspectives to guide me in designing and implementing circumscribed psychological interventions. Essentially, I ask myself, “What needs to change psychologically or environmentally to help this patient return to her or his pre-hospitalization level of functioning?” Sometimes this involves helping the patient negotiate a difficult life transition. Sometimes it involves teaching skills to cope better with one’s own emotions or situations. Sometimes, it involves a marital or family intervention.

In outpatient settings, I use an Integrative Cognitive Behavioral model with particular emphasis on Dialectical Behavior Therapy, ACT (Acceptance and Commitment Therapy), Motivational Enhancement Therapy approaches. Currently, I’m working on developing a standardized Life Values intervention to assist patients in clarification of their own Life Values hierarchy and examination of the congruence (or lack of congruence) between their actual behavior and what they say they value. The goal of such an intervention is to increase awareness of any discrepancy between attitudinal values and behavioral valuing and, then to utilize awareness of this discrepancy to motivate self-determined change in the patient’s behavior. The hypothesis, is that such an intervention will enhance patient readiness and willingness to change. In addition to individual therapy, I utilize group skills training in Mindfulness, Emotion Regulation,

Distress Tolerance, and Interpersonal Effectiveness to enhance the Action phase of change.

Emmanuel Papadakis, Psy. D.

I utilize brief therapy, cognitive- behavioral, interpersonal and systems approaches in assessing and treating veterans at the Dayton VA Medical Center.

Understanding how aging, medical illness effect the individual's ability to function at home, work and community is of utmost importance. Cost-effective assessment of problems and working with in the medical center and community systems - in order to help the veteran and his family to cope with stress is essential.

Neuropsychology

Description

The purpose of clinical neuropsychology is the assessment of brain-behavior relationships. The relationships are examined through a variety of measures utilizing a flexible procedure approach. Each examination assists in identifying the etiology, brain region, and extent of impaired functions along with well preserved abilities. Assessments are requested from disciplines across the full spectrum of patient care providers for an equally full range of purposes. The nature of a given assessment can range from a brief interview to a very involved series of tests and procedures. Throughout the rotation there is a series of readings on various topics (mental status, neurology, attention, executive functions, etc.) along with regular supervision meetings to discuss them. Additional learning experiences are obtained through contact with Radiology, brain cuttings, Neurology Clinics, quarterly peer review meetings, and state neuropsychology meetings.

Within the overall programmatic structure of the residency program, there is a strong apprenticeship approach with the neuropsychology rotation. The general structure is for the supervisor to begin with a directive style and move toward a consultant, or even independent, role relative to a given professional skill as a resident demonstrates competence consistently in that particular skill. Initially, direct observation of the supervisor is the modal style. Almost simultaneously, there is training in the various tests and procedures used customarily in a neuropsychological assessment. The nature of the relationship evolves to the supervisor observing the resident administer tests along with a careful review of all protocols. Usually, report writing begins with the administration of one's first series of tests. There is considerable structure so the process is more of a "filling in the blanks." Eventually, the resident brings in a completed protocol and report for review. Rather quickly the number of assessments by a resident becomes a minimum of two per week. The usual schedule is face to face testing during the morning and writeup during the afternoon. Such a structure serves to maximize the experiential learning component. During the initial learning phases, the supervisor will adopt a directive role in report writing in order to insure timely completion

of documentation. Although there is a large amount of structure on which to base the learning process, the development of individual style is encouraged and supported once a resident has demonstrated competence in the basic processes of an assessment.

Progress through the rotation is measured both quantitatively and qualitatively: more assessments, more complex assessments, less direct supervision, more independence with the process, faster completion of full reports, more sophisticated tests/procedures, etc.

Although the basic training structure remains the same, training is oriented to two different tracks. One is for a resident who wishes a workable knowledge of neuropsychology within the context of a well rounded residency experience. Any resident is considered qualified for the track. The other is for a resident who has aspirations of becoming a clinical neuropsychologist through a two year post doctoral training experience. Customarily, the latter opts for a 6-2-4 structure – though it is not required. Competency levels have higher thresholds since a superlative letter of recommendation from the supervisor is required and the supervisor prefers to adhere to Division 40 Guidelines. Acceptance into the track is not automatic and is at the discretion of the supervisor. If you have aspirations for a post doctoral position in clinical neuropsychology, be sure to make such intentions clear as part of your application. Supervisor: Dr. R. L. Stegman.

Conceptualization Statements

Anthony Byrd, Psy. D.

The practice of clinical neuropsychology involves the quantitative and qualitative evaluation of brain functions by measuring and assessing their cognitive and behavioral correlates. These are assessed with regard to an individual's relative cognitive strengths and weaknesses, and within the historical context of the myriad means by which brain damage and its consequent cognitive-behavioral dysfunction may occur. While there are various approaches or schools of thought by which neuropsychological assessment may be competently accomplished, I believe the most efficacious means of doing so is first and foremost through possession of a broad and deep foundational knowledge base, and in the use of a flexible approach to neurocognitive evaluation.

A sound foundational knowledge base, to include an understanding of so-called "normal" cognition and behavior, cognitive dysfunction and psychopathology as defined by validated diagnostic nomenclatures, knowledge of neuroanatomy and function, common neurological disorders and their manifestations, as well as the risk factors for susceptibility to brain dysfunction and the devices and normative data used to assess these, are absolute necessities.

Given that our national population is rapidly aging with many living longer, the likelihood of greater numbers of individuals who will, at some point, need an evaluation of their competence to live independently and to competently adapt to their environments, make

decisions, or who will require confirmation of the need for prescriptive intervention or evidence of its efficacy, will only increase. I have certainly found this to be true with this VA population, for whom I have provided neuropsychological services over the last years.

With these facts in mind, knowledge of the diseases and conditions often or exclusively associated with aging that adversely affect adaptive functioning, such as Mild Cognitive Impairment due to cardiac arrest , for example, or Alzheimer's Dementia, Stroke or Vascular Dementia is imperative for any neuropsychological practitioner. Furthermore, as brain disease and injury are not the exclusive domain of the aged, one must be versed and experienced in the following common central nervous system problems, including but not limited to: Transient Ischemic Attacks, Parkinsons' Disease, Multiple Sclerosis, Transient Global Amnesia, Alcoholic Dementia, Korsakoff's Disease, neurosurgical intervention sequelae, seizure disorder effects, chronic, severe mental illness, iatrogenic difficulties associated with long-term psychoactive medications, and of course Traumatic Brain Injury. Such a breadth of knowledge is imperative, in that it is within the context of the history and known course of these disease processes, conditions, injuries and illnesses (along with familiarity with neuroanatomical structure and function), in confluence with attendant risk factors for brain dysfunction, that an evaluation must be interpreted in order to be effective. It is my firm belief that a neuropsychological evaluation must demonstrate the neuropsychologist's THINKING and her/his conceptualization of the patient's performance and conditions affecting performance, rather than a written narrative of often minimally useful and potentially confusing array of age-scaled scores, standard scores, percentages and ranges of performance.

In accomplishing such a task, I have found the most effective means within this VA medical setting and patient population to be the use of a "core" group of neuropsychological measures, along with the use of additional measures as indicated by the explicitly determined purpose of the evaluation, the clinical/collateral interview findings, and the individual's ongoing performance and reaction to the testing process. While this approach requires a comprehensive knowledge base and relies on qualitative aspects as well as the quantitative patient performance, it allows (and demands) that the practitioner generate active clinical hypotheses, make in vivo evaluation judgments and instrument selections, and it affords more specific clarification of cognitive findings and diagnoses. I have also found this flexible approach to evaluation to support more parsimonious use of clinical time and, more importantly, it prevents subjecting the patient to unnecessarily lengthy testing sessions and procedures. The latter is especially true and pragmatic with the most aged and debilitated of patients, often having multiple co-morbidities. This non-fixed battery process as described, I feel, allows for a richer neuropsychological profile that, at the same time, is better fashioned to respond to the specifics of the reason(s) for referral over a more "fixed" battery approach to assessment or a "screening only" approach to neurocognitive evaluation.

While the practice of clinical neuropsychology will continue to evolve over time due to: the necessity for increasingly ecologically valid, meaningful and efficient appraisals of

the brain-behavior interface, the changing scope and footprint of managed care practices, the advent of new and more incisive (functional) imagining devices, a solid foundation in brain-behavior functions and structure, normality and dysfunction, illness and injury, psychopathological conditions and proper test selection required to validly and reliably assess these, will always be a necessary aspect of a comprehensive assessment of individual human cognitive capacities.

AS OF AUGUST 1st 2006, THE FOLLOWING ROTATIONS ARE NOT AVAILABLE FOR TRAINING YEAR 2007-2008

(However, applicants are encouraged to periodically check on their availability as this may change on short notice. Any changes will be posted ASAP).

Geropsychology

Description

The geropsychology rotation incorporates a variety of clinical work with an inpatient elderly population. Geropsychological services are provided to multiple units on the medical center campus: the Hospice/Palliative Care Unit, the Nursing Home Care Units, and the secured Geriatric/Dementia Unit. The rotation offers the resident a wide variety of assessment, intervention, and consultative experiences involving the care and treatment of geriatric patients within the context of an interdisciplinary team approach. Specific resident activities will be determined by resident-supervisor goals, the resident's interests, and prior level of training as well as rotation competency requirements. Previous geropsychology and neuropsycholology experience are not prerequisites for the rotation. Examples of professional psychology activities include: individual, family, and group therapy; psychological/emotional and cognitive assessments; behavior management assessment, planning, and implementation; and attendance at family meetings with the treatment team. In addition to providing such clinical services, a resident will respond to consultation requests and provide pertinent oral and written feedback to staff as well each patients and families. The rotation provides a unique opportunity for the resident to acquire an appreciation of issues impacting on an aging population such as dementia, delirium, cognitive assessments, death and dying, psychology and spirituality, adjustment to physical and mental decline, and psychiatric conditions in the elderly. The acquisition of this knowledge can come from multiple sources including weekly didactics with the rotation supervisor, VHA medical center sponsored seminars, readings, interactions with experienced interdisciplinary team members, and clinical work. In addition to the clinical duties, each resident is required to complete a rotation "project" (read three books on death and dying provided by the supervisor, keep a journal reflecting on hospice experience, and turn in a brief paper at the end of the rotation), complete assigned readings, and attend regularly scheduled supervision meetings. Supervisor: Dr. Nicole Best.

Conceptualization Statement

Nicole A. Best, Psy.D.

Although true with clients of any age, culture, gender, or health status, it is especially important when working with geriatric and medically ill individuals that a biopsychosocial model be the foundation of any theoretical conceptualization. We are all spiritual, physical, mental, and social beings who are constantly and simultaneously functioning at each of these levels. When only a few years ago it was on the "cutting edge" to talk about the mind-body connection, today researchers are accepting the notion of a "Bodymind" – one entity, with thoughts and feelings causing physical changes; and cellular activity, hormonal secretions, and peptides transmitting messages back to the brain in a never-ending cycle.

The field of Psychoneuroimmunology has led the way in revealing the significant impact that relaxation, exercise, laughter, prayer, positive thinking, and emotional expression can have on physical health. Just as medications have been shown to alter brain chemistry, so too have lifestyle factors such as activity level, thought patterns, behaviors, and diet. Not only are neurotransmitters being studied, but so too are the consequences that prolonged stress and mood disturbances may have on actual brain structures. We are truly embarking upon discoveries that will lead us to unexplored areas of intervention.

Over and above a biopsychosocial basis, an appreciation for the roles of grief and spirituality become essential when working with a geriatric population. Whether terminally ill, residing in a nursing home, or continuing to function in the community, aging brings multiple losses and raises core existential questions. It is a time when many individuals have a need to review the story of their life, and to find meaning in past trials and triumphs, as well as in current illnesses and suffering. It is for some, the first and last time they will contemplate their place in the universe, a relationship with a Higher Power, their life's mission, and whether they believe they have reached a satisfactory conclusion.

Working with individuals at this stage of their life's journey necessitates a solid common factors approach, grief work, and an ability to be flexible (eclectic) in interventions (e.g. existential, cognitive behavioral) based on the client's presenting issues, personality, belief system, cultural background, cognitive abilities, and readiness for change.

Although continually evolving, much of my inspiration at this point in my own professional development comes from: the works of countless psychologists and physicians who are dedicated to the exploration of the mind-body connection, spirituality, and healing (e.g. Bernie Siegel, Harold Koenig, Joan Borysenko, J.K. Kiecolt-Glaser and R. Glaser); neuropsychology; the Death and Dying and Near-Death Experience literature (e.g. Elizabeth Kubler-Ross, Therese Rando, J. W. Worden); and the Hospice philosophy, as well as my own faith and lessons learned from the best teachers of all – dying patients whom I have had the privilege to know.

Post Traumatic Stress Disorder Day Hospital Program PTSD Clinical Team

Description

The Posttraumatic Stress Disorder Day Hospital Program is a day hospital program for up to 15 patients under the direction of a psychologist. All of the patients live in the domiciliary and are expected to attend the daily routine of mostly group treatment. The program provides state of the art treatments including virtual reality and Eye Movement Desensitization Routine to veterans. Treatment for Post Traumatic Stress Disorder (PTSD) is not limited to war zone related stress. Patients are expected to attend a trauma processing group, a life span group, an anger management group, a sleep hygiene group, a stress relaxation group, and a psychoeducational group. The patients are also involved in a community government and are expected to be in individual therapy. Residents function as a member of the treatment team. This program usually employs a practicum student from a nearby university and the resident is expected to supervise the student as part of their responsibility.

The PTSD Clinical Team offers outpatient treatment to patients with PTSD. Patients are offered a menu of different treatment formats that include individual and group therapies. Supervisor: Dr. Peggy Arnott.

Conceptualization Statements

Peggy Cisneros Arnott, Ph.D.

Working with veterans with Post-Traumatic Stress Disorder affords me the opportunity to work with a complex population and use a variety of approaches largely driven by "where the veteran is at." The majority of the veterans I see in therapy are combat veterans. Although the majority are Vietnam War era veterans, I also provide services to WWII, Korea, and Persian Gulf veterans. My responsibilities include conducting diagnostic assessments, treatment planning and conducting individual and group psychotherapy.

A person can be seen as not only a sum of his/her experiences, but also how those experiences are interpreted and internalized. I attempt to see my patients in a holistic fashion. Trained with a developmental background, I find it extremely important to know about any past trauma history and what s/he was like before they were exposed to trauma. Understanding post-trauma lifestyle is also essential as I try to "paint" the picture of this veteran, including his/her strengths. I consider myself as having an integrative theoretical orientation, mostly humanistic, interpersonal, and cognitive-behavioral. For assessment purposes I rely mostly on clinical interviewing, although on occasion I will use objective personality measures to help with my conceptualization of

the veteran. I also believe in forming a collaborative alliance with the veterans, giving them responsibility for the pace and topics to be discussed in treatment.

My understanding of trauma is that it is an event(s) that impacts our biology, social functioning, emotional integrity and calls into question the very core of our existence. Issues of guilt and spirituality are commonplace as veterans explore how they survived their traumas. My multifaceted view of how trauma impacts the self is manifested in my practice as I espouse eclectic pragmatism. With an overall interpersonal approach, I use a variety of therapeutic techniques and schools of thought to understand and assist the veterans I work with. This includes cognitive-behavioral techniques to teach relaxation training, stress management and mastery over triggers, or more existential therapies as veteran's struggle with the "why's" that trauma seems to generate. The roles of unresolved grief, limited emotional expressiveness and spirituality become essential when working with many trauma survivors. All the while, reflective and empathic listening are used in order to provide a safe environment where the veteran can chose to experience some very intense emotions. With certain veterans, trauma processing can be very beneficial as we "go back" to the trauma in order to understand this experience's bearing on their life today.

I see myself as an educator, helping veterans understand the effects of trauma. I find it valuable to spend time helping them understand PTSD and it effects on their lives. At the outset of therapy, many veterans state that they feel like they are "going crazy." Spending time helping them understand PTSD helps them feel more "normal" providing much needed validation as well. I teach them about mind-body interactions by helping them identify and master their triggers as they attempt gain some control back of their bodies and thoughts. The purpose is to empower the veteran, since one of the main diagnostic criterias of PTSD is having feelings of helplessness and powerlessness during the trauma.

What we hope to achieve is that a veteran that we work with feels good enough about his understanding of and mastery of PTSD symptoms that s/he can function independently without our help. We are not always likely to see remission of all symptoms, but we hope to help them gain some mastery over symptoms by taking a proactive approach to dealing with symptoms. We encourage healthy behaviors and refer to many hospital clinics to help the veteran take care of his overall health which, as we know, impacts his/her outlook on life and mood.

Substance Abuse Treatment and Rehabilitation Program

Description

The Substance Abuse Treatment and Rehabilitation Program (SATRP) is a residential and outpatient multidisciplinary approach to polysubstance abuse and dependence that includes a dual diagnosis approach. A variety of disciplines are integrated into the treatment process: psychiatry, psychology, social work, substance abuse counseling, nursing, chaplain services, vocational rehabilitation, dietetics, and recreation. The

program is structured to encourage participation and cooperation among the patient and the staff to encourage the processes of recovery. The psychologist serves as an integral member of the dual diagnosis team. Psychological assessments to assist in the development of individualized treatment are routine along with the provision of consultation services. In addition, a major role of the psychologist is to provide individual and group interventions.

Conceptualization Statement

Position vacant at this time.

ADDITIONAL TRAINING EXPERIENCES AND SUPPORT

Training Seminars

There is an ongoing didactic series throughout the residency year. The meeting time is each Wednesday, 1000 – 1200. The subjects and presenters are quite varied. Attendance is mandatory. We have been a process of sharing didactics and resources with two other psychology residency programs in the immediate area. The arrangement provides breadth and depth to the training experiences.

Group Supervision ????

Each Wednesday, 0900 – 1000, is group supervision. The general approach is to augment supervision taking place in other settings and to provide a venue in which residents can support their mutual professional development. Specific subjects are quite varied: case presentations, mandatory medical center training, practice oral defense of dissertation, administration of residency program, concepts/theories, etc. Attendance is mandatory.

Testing Laboratory

Medical records are totally computerized – to include a wide variety of personality inventories, self rating forms, etc. We maintain and update regularly an extensive selection of noncomputerized psychological tests and neuropsychological instruments.

Library

The Health Sciences Library houses many volumes of professional books and subscribes to over 300 professional journals. Staff are experts in completing literature searches and obtaining copies of articles and borrowing books from other institutions. Also, the library has an extensive collection of audio, video, and microfilm holdings.

Medical Media

Medical Media is available to assist the hospital staff with a variety of services including photographs, graphic art, and video production. The staff are quite helpful with teaching and the development of presentations.

Professional Development

A resident will be given a reasonable amount of authorized absence to attend professional presentations, conferences, workshops, and organizational meetings that are consistent with professional development plans. We support strongly the completion of the dissertation and allow a maximum of six days of authorized absence for trips to the university, oral defense, etc. Also, if appropriate, a resident may select a four hour block of time each week for the purpose of dissertation work. Finally, each resident is encouraged to make use of the many educational presentations within the medical center and the surrounding academic community.

PHYSICAL SETTING AND SUPPORT

Primary resident offices are located in 9D-132 of Building 330 (the Patient Tower). Each resident has an individual office along with a workstation (computer connected to the mainframe) along with a telephone that has voice mail. Two psychologists are located in the suite. Two conference/multipurpose rooms are part of the suite as well. Mental Health Clinic offices and Inpatient Mental Health are located on the 7th floor of the Patient Tower. There is an office, along with a workstation, in Mental Health Clinic for the residents. The Post Traumatic Stress Disorder Residential Rehabilitation Program and Substance Abuse Treatment Program each as an office, along with workstation, for a resident.

Medical records are electronic and almost all of the professional activities are accomplished through use of various computer programs. The first week of the academic year is devoted almost entirely to training in the various computer programs so that within a few days each resident has access to all the computer programs and is, therefore, able to engage in the full range of psychological services. The standard programs are the Computerized Patient Record System (CPRS) which exists in a dual form (Graphic User Interface and List Serve – the latter is a more DOS based system which is being phased out), psychological tests, Microsoft Outlook, Microsoft Word, Microsoft Windows 2000, Excel, Power Point, and Internet.

APPLICATION

Eligibility

An applicant must be a U.S. citizen who is enrolled in a clinical or counseling psychology graduate program that is accredited by the American Psychological

Association. We require that all academic requirements, other than dissertation, be completed prior to the beginning of the residency year. We strongly desire that a prospective applicant be sufficiently advanced with the dissertation so that completion can be anticipated by the end of the residency year.

The VHA Medical Center, Dayton, Ohio maintains a policy of equal employment opportunity in resident recruitment and retention. All recruitment processes are consistent with existing federal laws, guidelines, and policies.

Appointment and Benefits

Technically, each resident receives a one to three year temporary appointment per Department of Veterans Affairs regulations. The type of appointment translates to an actual one year plus one day appointment. There is a specific reason for such technicalities. The arrangement allows us to provide the benefits provided to any regular employee such as health insurance.

The residency year will begin on Monday, August 20, 2007. The total number of hours is 2,088 to include established holiday leave, annual leave, and sick leave. Annual leave and sick leave are accrued at a rate of four hours per pay period. We are not authorized funds to purchase unused annual leave. Sick leave can be accrued and maintained “on the books” indefinitely and used if one should become a federal employee at some time in the future. For the purpose of state licensure, our procedure is to verify the usual and customary 2,000 hour internship/residency. The pay is $23,164 for the year to be paid in equal installments over 26 biweekly pay periods.

As a federal employee, drug screens and background checks are routine. Prior to the actual appointment, a matched applicant must complete the appropriate paperwork and complete a physical examination that certifies s/he is capable of the duties required. The Department of Veterans Affairs, and consequently this medical center, adheres to the Americans With Disabilities Act and will provide reasonable accommodations for an individual who informs us that s/he has a disability.

The official appointment as a Psychology Resident is contingent upon successful completion of practica and academic requirements (other than dissertation) along with continued professional conduct consistent with quality practice of psychology.

Dissemination of information about the Psychology Residency Program is designed to be consistent with the concept of informed consent. We take care to ensure that each applicant, and especially each who is invited for an interview, receives considerable information so that s/he can make high quality informed decisions about our site relative to his/her professional development plans. Decisions on our part regarding an applicant are based upon the assumption of informed consent. We require accurate and complete factual information, as well as complete empirically based qualitative judgments, in order to make informed professional decisions that are of high quality regarding each applicant, resident, or graduate. The requirement supercedes any and

all prior decisions, nondisclosure agreements or judgments, and/or similar arrangements whether formal, informal, tacit, and/or passive in nature. The requirement does not include the usual and customary professional development struggles or issues. Our overwhelming experience has been that provision of accurate and complete factual information, along with empirically based qualitative judgments, consistent with the concept of informed consent is routine – though exceptions occur. Acquisition of knowledge that there were one or more apparent and noteworthy acts of omission and/or commission that misled us significantly in professional decision making processes is likely to be considered by the training committee as justification to reevaluate the status of an applicant, resident, or graduate**.** Feel free to contact us if you have any questions.

Application Procedures

We use the uniform application and add a sheet unique to our residency program. The additional sheet is included with this brochure. We adhere to the Association of Psychology Postdoctoral and Internship Centers (APPIC) guidelines for the recruitment and selection of psychology residents including the policy that no person at this training facility will solicit, accept, or use any ranking related information form any applicant prior to Uniform Notification Day.

We need the following documents

APPIC Uniform Application: available on the Internet at www.appic.org

A resume or curriculum vita.

Official transcripts of graduate work. The transcripts should cover all post baccalaureate course work.

Three letters of recommendation from professionals who are familiar with your academic and professional competencies.

Completed Interview Dates / Rotation Preference Form (unique to our site).

The deadline for receipt of application materials is December 1, 2006. Our preference is that all the materials be included in a single, large envelope. We do not require it, however. Please insure that letters of recommendation, the verification form, and transcripts are enclosed in appropriately sealed envelopes.

Our procedure is to review each application in detail and invite 28 applicants for interviews. The customary agenda is for the applicants to meet with the Professional Chief and Directors of Training as a group. Each applicant meets with three different supervisors who are chosen based upon rotation preferences. Applicants meet with current residents as a group in a totally nonevaluative information sharing meeting. Finally, there is a general meeting among all applicants, supervisors, and current

residents. We encourage applicants to become familiar with our staff and setting to assist in the decision making process. We try to schedule seven applicants per interview day. We do not schedule more than eight on a given day as a greater number overtaxes our resources. Our practice is to make the 28 applicants, who are invited for interviews, our pool for the purpose of match day. That is, further reductions in the pool of applicants are unlikely.

If you are unable to be present for a scheduled interview date, we can arrange a conference call telephone interview. On site interviews on other than the specified dates will be less formal and be accommodated to the extent that they do not interfere with patient care duties.

Scheduled interview dates are:

Friday, January 5, 2006, 0800 – 1215

Monday, January 8, 2006, 0800 – 1215

Thursday, January 11, 2006, 1200 – 0415

Tuesday, January 116, 2006, 1200 – 0415

DIRECTIONS TO THE VHA MEDICAL CENTER, DAYTON, OHIO

Interstate Road 70 runs east-west a few miles north of Dayton. Interstate road 75 bisects Dayton in a north-south direction and US 35 bisects Dayton in an east-west direction. The VHA Medical Center is on the west side of Dayton. Visitors are advised to use US 35 west from the Interstate Road 75 / US 35 interchange. Take US 35 west to Liscum Drive (second traffic light). The medical center is on the right. The Patient Tower is the only nine story building in the area. If you need further directions, lodging information, or have other questions, please feel free to contact use using telephone or email. Also, a map is part of the Dayton VHA Medical Center Web Site at www.dayton.med.va.gov

Our main offices are located on the 9th Floor, Room 9D-132 of the Patient Tower (Building 330). Parking is free throughout the medical center and ample parking is available on the south and west sides of the Patient Tower – though please be prepared to walk a distance.

MATCH DAY

The official dates for the 2007 – 2008 academic year are as follows:

- Wednesday, February 7, 2007: Deadline for submission of Rank Order Lists.

- Friday, February 23, 2007: Applicants informed as to whether or not they were matched.
- Monday, February 26, 2007: APPIC Match Day.

Immediately after learning the names of applicants with whom we have been matched, a CoDirector of Training will contact each through email and/or telephone. Also, s/he will be mailed two signed copies of a letter confirming the match. Each applicant is to return one copy of the letter after signing it.

PSYCHOLOGY TRAINING COMMITTEE

Aaronson, Arthur L.

Psy.D., clinical, 1988, Wright State University School of Professional Psychology.
Staff Psychologist, Mental HealthCare Line.
At VHAMC-Dayton since 1988.
Licensed Psychologist, State of Ohio.
Professional Organizations: American Psychological Association (APA), Divisions 12-Clinical Psychology, 18-Psychologists in Public Service, 41-American Psychology-Law Society.
Research Interests: MMPI/MMPI-2 and using assessment instruments to predict outcome success.
Clinical Interests: assessment, psychopharmacology.

Arnott, Margaret I.C.

Ph.D., counseling, 2000, The Ohio State University
Staff Psychologist, PTSD Clinical Team
At VHAMC-Dayton since 2000
Licensed Psychologist
Professional Organizations: American Psychologist Association (APA)
Research Interests: Quality of life issues in PTSD
Clinical Interests: group psychotherapy, assessment, marital therapy
Theoretical Orientation: Integrated

Best, Nicole

Psy.D. clinical, 1997, Wright State University School of Professional Psychology
Staff Psychologist, Geriatric Extended Care Line
At VHAMC-Dayton since 1999
Licensed Psychologist, State of Ohio
Professional Organizations: American Psychological Association (APA), Ohio Psychological Association.
Research Interests: psychoneuroimmunology, cancer, psychology and spirituality, sports psychology and performance enhancement
Clinical Interests: geropsychology, psychological interventions with terminally ill patients, grief work, end of life issues, neuropsychology, health psychology, psycho-education, narrative therapy.
Theoretical Orientation: eclectic (common factors, cognitive-behavioral, existential, and psychodynamic conceptualizations)

Byrd, Anthony

Psy.D. clinical, 1989, Wright State University School of Professional Psychology
Clinical Neuropsychologist, Mental Health Care Line.
At VHAMC-Dayton since 1992.
Licensed Psychologist, State of Ohio & Arizona
Professional Organizations: American Psychological Association (APA), Division 40, National Academy of Neuropsychology.
Clinical Interests: neuropsychology, dementia, psychopharmacology.
Theoretical Orientation: Eclectic

Graham, Rebecca L.

Ph.D., clinical, 1991, University of Louisville.
Staff Psychologist, Inpatient Mental Health/Emergency.
At VHAMC-Dayton since 1991.
Licensed Psychologist, State of Ohio.
Professional Organizations: Society for Personality Assessment.
Clinical Interests: personality assessment; brief psychodynamic psychotherapy; group therapy.
Theoretical Orientation: interpersonal/psychodynamic.

O'Brien, William F.

Ph.D., counseling, 1975, Ohio State University.
Manager, Mental Health Care Line. Lead Psychologist.
At VHAMC-Dayton since 1984.
Licensed Psychologist, State of Michigan.
Professional Organizations: American Psychological Association (APA), Division 18-Psychologists in Public Service (officer); Association of VA Chiefs of Psychology (officer).
Research Interests: substance abuse; PTSD.
Clinical Interests: substance abuse; PTSD.
Theoretical Orientation: eclectic - client centered.

Papadakis, Emanuel A.

Psy.D., clinical, 1987, Wright State University School of Professional Psychology.
Staff Psychologist, Mental Health Care Line.
At VHAMC-Dayton since 1992.
Licensed Psychologist, States of Ohio and Indiana.
Professional Organizations: American Psychological Association (APA).
Research Interests: chronic illness; primary prevention.
Theoretical Orientation: biopsychosocial model; systems theory; solutions orientation.

Peterson, Frederick L. Jr.

Psy.D., clinical, 1985, Wright State University School of Professional Psychology.
CoDirector of Training, Staff Psychologist, Primary Care / Health Psychology.
At VHAMC-Dayton since 1985
Licensed Psychologist, State of Ohio.
Professional Organizations: AIDS Foundation of Miami Valley, American Association of Sex Educators, Counselors, and Therapists, American Board of Sexology, American Psychological Association (Div 51), American Lung Association.
Research Interests: Smoking cessation, organizational assessment and consultation, gender and management, HIV and volunteerism, sex education and therapy, sexual trauma, men's studies.
Clinical Interests: clinical sexuality, smoking cessation, health psychology, primary prevention in psychology, getting psychology out of the box.
Theoretical Orientation: psychological pragmatism.

Verdaguer, Ramon

Ph.D. Clinical, 1990, Loyola University of Chicago.
ABPP, Clinical Health Psychology
Co-Director of Training, Staff Psychologist, Primary Care/Health Psychology
At VHAMC-Dayton since 1996.
Licensed Psychologist, State of Ohio and Illinois (inactive).
Professional Organizations: Div. 38, APA.
Research Interests: Positive psychology.
Clinical Interests: Wellness and health promotion, pre-surgical psychological evaluations
Theoretical Orientation: Cognitive-Behavioral.

INTERVIEW DATES AND ROTATION PREFERENCES[1]

Interview Dates

Please rank your preferred interview dates. We will contact you to arrange an interview.

	Morning	Afternoon
Friday, January 5, 2007	_____	
Monday, January 8, 2007	_____	
Thursday, January 11, 2007		_____
Tuesday, January 16, 2007		_____

Rotation Preferences

Please rank order your three rotation preferences. Remember that, regardless of rotation, each resident spends one day per week in the Mental Health Clinic setting.

Health Psychology	_____
Mental Health	_____
Neuropsychology	_____
Geropsychology	N/A (2007-2008)
PTSD Residential Rehabilitation Program	N/A (2007-2008)
Substance Abuse Treatment Program	N/A (2007-2008)

If you wish a six month rotation, please note it below.

_____
(name)

[1] Pleased be advised that, for a number of reasons, we are in the process of redeveloping some of the rotations. We will try to update the brochure regularly.